STATE OF NEVADA
CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF COVERED SERVICEMEMBER FOR MILITARY FAMILY LEAVE (FAMILY MEDICAL LEAVE ACT)

NOTICE AND INSTRUCTIONS TO THE AGENCY: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Agencies must generally maintain records and documents related to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee is Requesting Leave.
INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The agency must give an employee at least 15 calendar days to return this form to the employer.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veteran's Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. (Note: A health care provider that does not meet the above criteria may fill out this certification if the covered servicemember is an Armed Forces veteran, see below.)
INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed below has requested leave under the FMLA to care for a member of the Armed Forces (including a member of the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness; or a veteran who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness who was a member of the Armed Forces (including a member of the National Guard or Reserves), at any time during the period of 5 years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy. A serious injury or illness is defined as in the case of a member of the Armed Forces (including National Guard or Reserves), an injury or illness that was incurred by the member in line of duty on active duty (or existed before the beginning of the active duty and was aggravated by service in line of duty on active duty) that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating; and in the case of a Armed Forces (including National Guard or Reserves) veteran, a qualifying injury or illness that was incurred by the member in line of duty on active duty (or existed before the beginning of the active duty and was aggravated by service in line of duty on active duty) and that manifested before or after the member became a veteran, at any time during the period of 5 years preceding the date on which the veteran undergoes medical treatment, recuperation or therapy.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty or was aggravated by service in line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime", "unknown", or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

<table>
<tr><td colspan="2">SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee is Requesting Leave: (This section must be completed first before any of the below sections can be completed by a health care provider.)</td></tr>
<tr><td colspan="2">Part A—EMPLOYEE INFORMATION</td></tr>
<tr><td>Name and Address of Agency (this is the employer of the employee requesting leave to care for covered servicemember):</td><td>Agency Contact:</td></tr>
<tr><td>Name of Employee Requesting Leave to Care for Covered Servicemember:

_____
(First) (Middle) (Last) (Employee ID #)</td><td>Name of Covered Servicemember (for whom employee is requesting leave to care):

_____
(First) (Middle) (Last)</td></tr>
<tr><td colspan="2">Relationship of Employee to Covered Servicemember Requesting Leave to Care:</td></tr>
</table>

Part B—COVERED SERVICEMEMBER INFORMATION

(1) Is the covered servicemember a current member of the Regular Armed Forces, the National Guard or Reserves? ☐ Yes ☐ No

If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to:

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?
☐ Yes ☐ No

a. If yes, please provide the name of the medical treatment facility or unit:

(2) Is the covered servicemember on the Temporary Disability Retired List (TDRL)? ☐ Yes ☐ No

(3) Is the covered servicemember a veteran of the Regular Armed Forces, the National Guard or Reserves? ☐ Yes ☐ No

a. If yes, when did the covered servicemember's active duty end: _____

Part C—CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the care to be provided to the covered servicemember and an estimate of the leave needed to provide the care:

SECTION II For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans' Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). Note: A health care provider that does not meet the above criteria may fill out this certification if the covered servicemember is an Armed Forces veteran with a qualifying injury or illness that was incurred by the member in line of duty on active duty (or existed before the beginning of the active duty and was aggravated by service in line of duty on active duty) and that manifested before or after the member became a veteran, at any time during the period of 5 years preceding the date on which the veteran undergoes medical treatment, recuperation or therapy. (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A—HEALTHCARE PROVIDER INFORMATION

Health Care Provider's Name:	Health Care Provider's Business Address:	Type of Practice/Medical Specialty:

Please state whether you are either:

☐ a DOD health care provider;

☐ a VA health care provider;

☐ a DOD TRICARE network authorized private health care provider;

☐ a DOD non-network TRICARE authorized private health care provider (Specify below); or

☐ a other health care provider (Specify below):

Telephone:

( )

Fax

( )

Email

Part B—MEDICAL STATUS

(1) Covered servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

☐ **(VSI) Very Seriously Ill/Injured-**Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD health care providers.)

☐ **(SI) Seriously Ill/Injured-**Illness/Injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD health care providers.)

☐ **OTHER Ill/Injured-**A serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **NONE OF THE ABOVE:** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete a separate form.)

(2) Was the condition for which the covered servicemember is being treated incurred in line of duty on active duty or existed before the beginning of the active duty and was aggravated by service in line of duty on active duty? ☐ Yes ☐ No

(3) Approximate date condition commenced:

(4) Probable duration of condition and/or need for care:

(5) Approximate date treatment commenced:

(6) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No

a. If yes, please describe medical treatment, recuperation or therapy:

Part C—COVERED SERVICEMEMBER'S NEED FOR CARE

(1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No

a. If yes, estimate the beginning date for this period of time:

b. If yes, estimate the ending date for this period of time:

(2) Will the covered servicemember require periodic follow-up treatment appointments? ☐ Yes ☐ No

a. If yes, estimate the treatment schedule:

(3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No

(4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? ☐ Yes ☐ No

a. If yes, please estimate the frequency and duration of the periodic care:

Signature of Healthcare Provider:	**Date:**